

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

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|---|--------------------------------|
| Requestor's Name and Address: INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PKWY. STE. G GRAND PRAIRIE, TX. 75050 | MFDR Tracking #: M4-09-B140-01 |
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| Respondent Name and Box #: AMERICAN HOME ASSURANCE CO. REP. BOX # 19 | |
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PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Sent within 95 days of service-Timely filed", "Timely Filed/Valid license #DC6273TX", "Timely Filed/Pre-Authorization #883684 / NPI #1881895852 provided in Box 33a", "Timely Filed/Pre-Authorization #883684 / Carrier incorrectly reviewed CPT code 97799 CP as 97799 9C", and "Pre-Authorization # 883684 / Per MAR Fee"

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought – \$2792.10 *
3. CMS 1500s
4. EOB
5. Medical Records
6. Pre-authorization letter

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary taken from the Table of Disputed Services: "Do {sic} not rec'd timely /rec'd 7/3/09", "Did not submit Dr. license number", "NPI not provided –bill incomplete", "modifier", and "Did not submit orig bill timely-carrier does not show having rec'd prior 7/3/09"

Principal Documentation:

1. CMS 1500s
2. Copies of carrier returned letter

PART IV: SUMMARY OF FINDINGS

| Eligible Date(s) of Service (DOS) | CPT Code(s) and Calculation(s) | Denial Code(s) | Part V Reference | Amount Ordered |
|-----------------------------------|--------------------------------|----------------|------------------|----------------|
| 8-12-08 | 99080-73 | 29 | 1, 2, & 3 | \$0.00 |
| | 99213 | 29 | 1, 2, & 3 | \$0.00 |
| 9-9-08 | 90801 | 29 | 1, 2, & 3 | \$0.00 |
| 11-10-08 | 97799-CP (x8 units/hours) | | 1, 2, & 3 | \$800.00 |
| 11-12-08 | 97799-CP (x8 units/hours) | 29 | 1, 2, & 3 | \$0.00 |
| 11-14-08 | 97799-9C (x8 units/hours) | | 1, 2, & 3 | \$0.00 |
| 12-10-08 | 99213 | 29 | 1, 2, & 3 | \$0.00 |
| Total Due: | | | | \$800.00 |

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code 402.00128(b) (7) titled *General Powers and Duties of Commissioner* authorizes the Commissioner to enter appropriate orders. The Division will resolve medical fee disputes according to Rules 133.305, 133.307, 133.20(b), 133.200, 133.240 and other rules. ** The Requestor withdrew DOS 11-18-08 and this DOS will not be included in this review. **

1. This dispute relates to procedures/services billed with CPT Codes 99080-73, 99213, 90801, and 97799-CP that were denied reimbursement by the insurance carrier based upon denial reason code “29” (the time limit for filing has expired-per Texas Labor Code 408.027 bills must be sent to the carrier on a timely basis, within 95 days from the dates of service).

2. Rule 102.4(h), titled General Rules for Non-Commission Communication, states “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.”

1. Section 408.027(a) of the Labor Code states, “A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.”

3. The Requestor provided written documentation to the Division supporting that one or more of these medical bill(s) were submitted timely to the carrier. (Specifically, the Requestor submitted a copy of the carrier’s letter that returned these bills deeming them incomplete.) There is no proof within the Requestor’s dispute that supports DOS 8-12-08 as being timely filed; no carrier letter returning this DOS as an ‘incomplete bill’; no proof of timely submission, this DOS will not be recommended for payment. In accordance with the ‘Texas Clean Claim guide’, Box 17a is a required field if Box 17 is populated. A review of the CMS 1500 forms for DOS 9-9-08 identify that Box 17a was not filled in although Box 17 was populated. The carrier returning this bill on 12-3-08 as ‘incomplete’ is correct and validated and therefore a complete medical bill for this DOS was not timely submitted. In accordance with the ‘Texas Clean Claim guide’, the NPI number of the rendering health care provider (HCP) is required in Box 33a. A review of the ‘electronically’ received CMS 1500 form for DOS 11-10-08 identifies the NPI number is listed in Box 33a; therefore, the carrier letter dated 12-30-08 returning this bill as incomplete for this missing information is not correct and not validated. Per Rule 134.204 (h) (1) (B) (5) (A) (B), payment is recommended for this DOS; as a complete medical bill was timely received for DOS 11-10-08. A review of the ‘electronically’ received CMS 1500 form for DOS 11-12-08 identifies that the NPI number is not listed in Box 33a as required. The carrier returning this bill on 12-30-08 as ‘incomplete’ is correct and validated and therefore a complete medical bill for this DOS was not timely submitted. A review of the ‘electronically’ received CMS 1500 form for DOS 11-14-08 identifies that the CPT code that was billed was ‘97799-9C’. The modifier appendage of ‘9C’ is not appropriate due to this is not a valid modifier; therefore, the carrier letter dated 12-24-08 returning this bill as ‘inappropriate modifier’ is correct and validated. There is no proof within the Requestor’s dispute that supports DOS 12-10-08 as being timely filed; no carrier letter returning this DOS as an ‘incomplete bill’; no proof of timely submission, this DOS will not be recommended for payment.

- 97799-CP: \$125.00 per hour if CARF
- 97799-CP: \$100.00 per hour if non-CARF (\$125.00 x 80%=\$100.00) \$100.00 x 8=\$800.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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|--|---|
| Texas Labor Code 402.00128(b)(7) | |
| Texas Labor Code 408.027(a) | 28 Texas Administrative Code Sec. 134.203 |
| Texas Labor Code Sec. §413.031 and §413.0311 | 28 Texas Administrative Code Sec. 133.20(b)(effective 5/2/06) |
| 28 Texas Administrative Code Sec. §102.4(h) | 28 Texas Administrative Code Sec. 133.2 |
| 28 Texas Administrative Code Sec. §133.305 | 28 Texas Administrative Code Sec. 133.240 |
| 28 Texas Administrative Code Sec. §129.5 | |
| 28 Texas Administrative Code Sec. §134.204 | |
| 28 Texas Administrative Code Sec. §133.307 | |
| 28 Texas Administrative Code Sec. §134.801(effective 9/1/05) | |
| Subchapter G, Chapter 2001, Texas Government Code | |

PART VII: DIVISION DECISION

The Division hereby orders the Respondent to reimburse the Requestor in accordance with Rule 134.204 plus interest for services included in the original bill for DOS 11-10-08 within 30 days of receiving this Order.

ORDER:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 512-804-4812.